	Liberioning and Certification
Proposed name of facility/agency/clinic	

## APPLICANT INFORMATION FOR SNFs, ICFs, ICF/DDHs, ICF/DDNs, AND CLINICS

## This form is intended for the following:

- 1. Any individual owning an applicant facility;
- 2. Each partner, each director, each officer of a corporation;
- 3. Each manager, each member of a limited liability company;
- 4. Each administrator of a Primary Care Clinic (PCC);
- 5. Each person having a beneficial interest of at least 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, or applicant management company of a SNF or ICF.

In addition to completion as part of an application package, this HS 215 A form should be completed for disclosure purposes when changes are reported in officers, directors, purchase of stock, etc., as required by law, **even though no change of ownership is occurring.** 

Other capacity, please specify:  2. Have you ever operated or managed (including management agreements) a:  SNF Community Care Facility Residential Care Facility for the Elderly Other capacity, please specify:  3. Have you ever held a 5 percent or more beneficial ownership interest in a:  SNF Community Care Facility for the Elderly Community Care Facility Other ownership interest, please specify:  4. Have you ever held a 10 percent ownership interest in any other facility category, such as:  CF/DD CICF/DD-H CICF/DD-N Clinic General Acute Care Hospital Home Health Ag  Other ownership interest, please specify:  5. Have you ever been involved in one or more of the following business entities that operated health or community care facilities.	A.	Ide	entifying Infor	mation [H&S 1	212, 1265, and	1267]					
Title in relation to this facility    Have you applied for ANY license for a health facility or community care facility regardless of your role or title using any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B belowing any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B belowing any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B belowing any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B belowing below name). It is thours spent at each clinic per week.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B belowing bounded in the enther entities that are licensed (please see Section B belowing information and completion of Section C is required [H&S 11267]. Please attach additional pages if necessary.	Nam							Date of birth			
Title in relation to this facility    Have you applied for ANY license for a health facility or community care facility regardless of your role or title using any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below the enther entities that are licensed (please see Section B below there entities that are licensed (please see Section B below there entities that are licensed (please see Section B this enther entities that are licensed (please see Section B below there entities that are licensed (please see Section B below there entities that are licensed (please see Section B below there entities that are licensed (please see Section B this entities that are licensed (please see Section B there entities that are licensed (please see Section B there entities that operated health or licensed (please see Section B there entities that operated health or somewhat are licensed (please see Section B there entities that operated health or community care facility are facility licensed in the section B, the following information and completion of Section C is required [H&S 11267]. Please attach additional pages if necessary.	Puoi	2000	address (number at	root anartment/quite n	umbor or letter if appl	iooblo)		City		State	ZID anda
Have you applied for ANY license for a health facility or community care facility regardless of your role or title using any name? If yes, list all other names.    Spouse's name if spouse has a financial interest in this en other entities that are licensed (please see Section B below the names).    Agency, Clinic Involvement (In or out of California) [H&S 1212, 1253, 1265 and 1267]   Have you served in any health facility, agency, or clinic as a/an:   Director	DUSI	11655	address (Humber, St	reet, apartment/suite m	umber or letter if appr	icable)		City		State	ZIF code
B. Facility, Agency, Clinic Involvement (In or out of California) [H&S 1212, 1253, 1265 and 1267]  1. Have you served in any health facility, agency, or clinic as a/an:    Director   Licensee   Manager   Member   Officer   Owner   Partner   Share     Other capacity, please specify:	Title	in rel	lation to this facility					If administrator, list I	nours spent at	each clini	ic per week.
B. Facility, Agency, Clinic Involvement (In or out of California) [H&S 1212, 1253, 1265 and 1267]  1. Have you served in any health facility, agency, or clinic as a/an:    Director   Licensee   Manager   Member   Officer   Owner   Partner   Share     Other capacity, please specify:											
1. Have you served in any health facility, agency, or clinic as a/an:    Director   Licensee   Manager   Member   Officer   Owner   Partner   Share     Other capacity, please specify:					or community care fa	acility regardless of ye	our role or title	Spouse's name if spother entities that ar	oouse has a fin e licensed (ple	ancial inte ase see S	erest in this entity and/or Section B below)
Director   Licensee   Manager   Member   Officer   Owner   Partner   Share   Other capacity, please specify:   2. Have you ever operated or managed (including management agreements) a:   SNF   ICF   Community Care Facility   Residential Care Facility for the Elderl   Other capacity, please specify:   3. Have you ever held a 5 percent or more beneficial ownership interest in a:   SNF   ICF   Residential Care Facility for the Elderly   Community Care Facility   Other ownership interest, please specify:   4. Have you ever held a 10 percent ownership interest in any other facility category, such as:   ICF/DD   ICF/DD-H   ICF/DD-N   Clinic   General Acute Care Hospital   Home Health Ag   Other ownership interest, please specify:   5. Have you ever been involved in one or more of the following business entities that operated health or community care faciliti   Corporation   Individual   Limited liability company   Management company   Partner   Other capacity, please specify:    • If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.	В.	Fa	cility, Agency	, Clinic Involve	ment (In or ou	ıt of California	a) [H&S 121	⊥ 2, 1253, 1265 a	and 1267]		
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□ SNF       □ ICF       □ Community Care Facility       □ Residential Care Facility for the Elderl         □ Other capacity, please specify:       □         3. Have you ever held a 5 percent or more beneficial ownership interest in a:       □ SNF       □ ICF       □ Residential Care Facility for the Elderly       □ Community Care Facility         □ Other ownership interest, please specify:       □       4. Have you ever held a 10 percent ownership interest in any other facility category, such as:       □ ICF/DD □ ICF/DD-H □ ICF/DD-N □ Clinic □ General Acute Care Hospital □ Home Health Ag       □ Home Health Ag         □ Other ownership interest, please specify:       □         5. Have you ever been involved in one or more of the following business entities that operated health or community care faciliti □ Corporation □ Individual □ Limited liability company □ Management company □ Partner □ Other capacity, please specify:         ■ If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.			☐ Other capa	icity, please specif	<sup>:</sup> y:						
Other capacity, please specify:  3. Have you ever held a 5 percent or more beneficial ownership interest in a:  SNF   ICF   Residential Care Facility for the Elderly   Community Care Facility   Other ownership interest, please specify:  4. Have you ever held a 10 percent ownership interest in any other facility category, such as:  ICF/DD   ICF/DD-H   ICF/DD-N   Clinic   General Acute Care Hospital   Home Health Ag   Other ownership interest, please specify:  5. Have you ever been involved in one or more of the following business entities that operated health or community care faciliti   Corporation   Individual   Limited liability company   Management company   Partner   Other capacity, please specify:  ■ If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.		2.	Have you ever	r operated or man	aged (including r	management agı	reements) a:				
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SNF       ICF       Residential Care Facility for the Elderly       Community Care Facility         Other ownership interest, please specify:       4. Have you ever held a 10 percent ownership interest in any other facility category, such as:         ICF/DD       ICF/DD-H       ICF/DD-N       Clinic       General Acute Care Hospital       Home Health Ag         Other ownership interest, please specify:			☐ Other capa	icity, please specit	<del>.</del> y:						
Other ownership interest, please specify:  4. Have you ever held a 10 percent ownership interest in any other facility category, such as:  ☐ ICF/DD ☐ ICF/DD-H ☐ ICF/DD-N ☐ Clinic ☐ General Acute Care Hospital ☐ Home Health Ag ☐ Other ownership interest, please specify:  5. Have you ever been involved in one or more of the following business entities that operated health or community care facilitic ☐ Corporation ☐ Individual ☐ Limited liability company ☐ Management company ☐ Partner ☐ Other capacity, please specify:  ■ If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.		3.	Have you ever	r held a 5 percent	or more benefici	al ownership inte	erest in a:				
<ul> <li>4. Have you ever held a 10 percent ownership interest in any other facility category, such as:    ICF/DD   ICF/DD-H   ICF/DD-N   Clinic   General Acute Care Hospital   Home Health Ag</li> <li>  Other ownership interest, please specify:    </li></ul>			SNF	☐ ICF	Residentia	l Care Facility fo	or the Elderly	☐ Commu	nity Care Fa	acility	
□ ICF/DD □ ICF/DD-H □ ICF/DD-N □ Clinic □ General Acute Care Hospital □ Home Health Ag □ Other ownership interest, please specify:  5. Have you ever been involved in one or more of the following business entities that operated health or community care faciliti □ Corporation □ Individual □ Limited liability company □ Management company □ Partnet □ Other capacity, please specify: □ If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.											
<ul> <li>Other ownership interest, please specify:</li></ul>											
<ul> <li>5. Have you ever been involved in one or more of the following business entities that operated health or community care facilities. Corporation Individual Limited liability company Management company Partners.</li> <li>Other capacity, please specify:</li> <li>If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&amp;S 1 1267]. Please attach additional pages if necessary.</li> </ul>			☐ ICF/DD	☐ ICF/DD-H	☐ ICF/DD-N	☐ Clinic	☐ General	Acute Care Hos	pital [	] Home	Health Agency
<ul> <li>□ Corporation □ Individual □ Limited liability company □ Management company □ Partner</li> <li>□ Other capacity, please specify:</li> <li>■ If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&amp;S 1 1267]. Please attach additional pages if necessary.</li> </ul>			☐ Other ownership interest, please specify:								
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If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1 1267]. Please attach additional pages if necessary.			☐ Corporation ☐ Individual ☐ Limited liability company ☐ Management company ☐ Partnership								
1267]. Please attach additional pages if necessary.			☐ Other capa	icity, please specit	<del>.</del> y:						
Facility name Percent of involvement (optional) Federal tax ID number (optional)							information a	nd completion of	Section C	is requi	ired [H&S 1253 and
	Facil	ity na	ame				Percent of inve	olvement (optional)	Federal tax II	D number	(optional)
Facility address (number, street)  City  State  ZIP code	Facil	ity ad	ddress (number, stre	et)			City		  S	tate	ZIP code

C.	Adverse	Adverse Actions [H&S 1265 and 1267]								
	Did any o	Did any of the following adverse actions take place while you served in any of the capacities checked in Section B?								
	_	final Medi-Cal decertification action ved by settlement	☐ Placed on probati☐ Revoked (whethe		<ul><li>☐ Receiver appointed</li><li>☐ Suspended</li></ul>					
	If yes, ple									
D.	Crimina	Record [H&S 1265]								
	1. Have	you ever been convicted of an of	fense that is still on your	record, whether misden	neanor or felony?	☐ Yes ☐ No				
		there been a judgment against yo essional/technical licensing entity′	a health care	☐ Yes ☐ No						
	If yes	s, please provide additional inform	ation:							
<u> </u>		ment/Business Summary (fo this type of facility. Attach a				that qualifies you	to			
	Date		Address of Employer(s)			ob Title				
Fro	om:									
То	:									
Fro	om:									
То	:									
Fro	om:									
То	:									
F.		ional Licenses/Certificates. ypes [H&S 1212].	This requirement is I	mandatory for Prima	ry Care Clinics a	and optional for hea	lth			
		Туре	Perio	d Held	Issuing Agency					
-							_			
		nder penalty of perjury that t my knowledge.	he statements on thi	is form and any acco	ompanying attac	hments are correct	to			
Sigr	nature				Date					
			Release of Inform	ation Statement			_			
Th	o informa	tion provided on this form is	mandatory and is no	coccary for liconouro	approval It will	he used to determ	ina			

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Health Services, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1278.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.